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Page 900.11

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
65 Laundry Contracted Services								
66 Other Laundry Expense_____								
67 Other Laundry Expense_____								
68 Other Laundry Expense_____								
69 Other Laundry Expense_____								
70 Other Laundry Expense_____								
71 Other Laundry Expense_____								
72 Other Laundry Expense_____								
73 Other Laundry Expense_____								
74 Other Laundry Expense_____								
75 *Total Laundry Expense*								
Administrative & General								
76 Salaries-Officers								
77 Salaries-Administrator								
78 Salaries-Office Staff								
79 Other Salaries_____								
80 Other Salaries_____								
81 Other Salaries_____								
82 *Subtotal-Salaries*								
83 Management Fees								
84 Home Office Costs								
85 Board of Directors Fees								
86 FICA								
87 Workmen's Compensation								
88 Unemployment Insurance								
89 Medical Insurance								
90 Life Insurance								
91 Telephone								
92 Dues & Subscriptions								
93 Office Supplies								
94 Equipment Rental								
95 Printing & Postage								
96 Legal Fees								
97 Accounting Fees								

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ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
98 Contracted Services								
99 Utilization Review								
100 Travel & Seminars								
101 Advertising-Help Wanted								
102 Advertising-Other								
103 Small Equipment Purchases								
104 Licenses & Fees								
105 Interest Expense-Non-Capital								
106 Other Expense_____								
107 Other Expense_____								
108 Other Expense_____								
109 Other Expense_____								
110 Other Expense_____								
111 Other Expense_____								
112 Other Expense_____								
113 Other Expense_____								
114 Other Expense_____								
115 Other Expense_____								
116 Other Expense_____								
117 Other Expense_____								
118 Other Expense_____								
119 Other Expense_____								
120 Other Expense_____								
121 Other Expense_____								
122 Other Expense_____								
123 Other Expense_____								
124 Other Expense_____								
125 Other Expense_____								
126 Other Expense_____								
127 Other Expense_____								
128 Other Expense_____								
129 Other Expense_____								
130 Other Expense_____								
131 *Total Admin. & General Exp.*								

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ANNUAL COST REPORT -- SCHEDULE D-4 -- CAPITAL COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
1 Depreciation-Building								
2 Depreciation-Equipment								
3 Interest Expense-Capital Related								
4 Rent								
5 Land Improvements								
6 Leasehold Improvements								
7 Amortization of Start-up Costs								
8 Other Capital Costs_____								
9 Other Capital Costs_____								
10 Other Capital Costs_____								
11 Other Capital Costs_____								
12 Other Capital Costs_____								
13 Other Capital Costs_____								
14 Other Capital Costs_____								
15 Other Capital Costs_____								
16 Other Capital Costs_____								
17 Other Capital Costs_____								
18 Other Capital Costs_____								
19 Other Capital Costs_____								
20 Other Capital Costs_____								
21 Other Capital Costs_____								
22 Other Capital Costs_____								
23 *Total*								

Grand Totals	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
24 Totals of Schedules D-1 through D-4								
25 Total of Schedule D-5, Column 8								
26 Total Routine CNF Cost								
27 Totals from Schedule D-5								
28 Total Cost								

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SEP 26 ...

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Page 900.14

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Physical Therapy							
1	Physical Therapist Salaries							
2	Physical Therapist Assistants Salaries							
3	Physical Therapist Aides Salaries							
4	Other Salaries							
5	*Subtotal-Salaries*							
6	Employee Benefits Reclassification							
7	Contracted Services							
8	Equipment Depreciation							
9	Other Expenses_____							
10	Other Expenses_____							
11	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col. 4)						
12	*Total*							
	X-Ray							
13	Professional Salaries							
14	Other Salaries							
15	*Subtotal-Salaries*							
16	Employee Benefits Reclassification							
17	Supplies							
18	Equipment Depreciation							
19	Other Expenses_____							
20	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4)						
21	*Total*							
	Laboratory							
22	Professional Salaries							
23	Other Salaries							
24	*Subtotal-Salaries*							
25	Employee Benefits Reclassification							
26	Supplies							
27	Equipment Depreciation							
28	Other Expenses_____							
29	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4)						
30	*Total*							

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ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNP Indirect Costs
	Oxygen/Respiratory Therapy							
31	Respiratory Therapist Salaries							
32	Respiratory Therapist Assistants Salaries							
33	Respiratory Therapist Aides Salaries							
34	Other Salaries							
35	*Subtotal-Salaries*							
36	Employee Benefits Reclassification							
37	Supplies							
38	Equipment Depreciation							
39	Other Expenses_____							
40	Other Expenses_____							
41	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 6, Col. 4)						
42	*Total*							
	Speech							
43	Professional Salaries							
44	Other Salaries							
45	*Subtotal-Salaries*							
46	Employee Benefits Reclassification							
47	Equipment Depreciation							
48	Other Expenses_____							
49	Other Expenses_____							
50	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 7, Col. 4)						
51	*Total*							
	Other							
52	Professional Salaries							
53	Other Salaries							
54	*Subtotal-Salaries*							
55	Employee Benefits Reclassification							
56	Equipment Depreciation							
57	Other Expenses_____							
58	Other Expenses_____							
59	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 8, Col. 4)						
60	*Total*							

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ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Drugs							
56	Pharmicist Salaries							
57	Other Salaries							
58	*Subtotal-Salaries*							
59	Employee Benefits Reclassification							
60	Drugs							
61	Equipment Depreciation							
62	Other Expenses_____							
63	Other Expenses_____							
64	Other Expenses_____							
65	Other Expenses_____							
66	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9, X Sch. F, Section B, Line 9, Col. 4)						
67	*Total*							

ANNUAL COST REPORT—SCHEDULE D-6—RECLASSIFICATIONS OF EXPENSES

VENDOR NAME_____ FYE_____

VENDOR NUMBER_____

Line	(1) Explanation	(2) Increase Amount	(3) Decrease Amount	(4) Cost Center Affected
1				
2				
3				
4				
5				
6				
7				
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58				
59				
60				
61	*Total*			

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ANNUAL COST REPORT—SCHEDULE D-7—ADJUSTMENTS TO EXPENSE

VENDOR NAME_____ FYE_____

VENDOR NUMBER_____

Line	(1) Explanation	(2) * Basis for Adjustment (A) or (B)	(3) Amount	(4) Sch. & Line # Affected
1	Laundry & Linen			
2	Employee & Guest Meals			
3	Gift, Flower & Coffee Shop			
4	Grants, Gifts & Income Designated by the donor for a specific purpose			
5	Beauty & Barber Shop **			
6	Excess Owners Compensation			
7	Telephone Serv.(Pay Serv. Excluded)			
8	Radio & Television Service			
9	Vending Machine Commission			
10	Sale of Drugs to other than Patients			
11	Sale of Medical & Surgical Supplies to other than Patients			
12	Sale of Medical Record & Abstracts			
13	Sale of Scrap, Waste, Etc.			
14	Rental of Quarters to Employees & Others			
15	Rental of Facility Space			
16	Trade, Quantity, Time & Other Discounts			
17	Rebates & Refunds of Expenses			
18	Interest Not Allowed			
19	Recovery of Insured Loss			
20	Depreciation			
21	Gain or Loss on Disposition of Assets			
22				
23				
24				
25				
26				
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49				
50				
51				
52				
53	*Total*			

* (A) COST (B) REVENUE

** *Beauty & Barber Shop Revenues in excess of Beauty & Barber Shop supply & personnel cost is to be adjusted in an Administrative & General cost center.*

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ANNUAL COST REPORT -- SCHEDULE E -- ANCILLARY SETTLEMENT

VENDOR NAME_____ VENDOR NUMBER_____ FYE_____

(1)	(2) Direct (From Sch. D-5, Col. 6)	(3) Medicaid Direct	(4) Medicaid Payments	(5) Receivable From KMAP (Payable To KMAP)
1 Physical Therapy				
2 X-Ray				
3 Laboratory				
4 Oxygen/Respiratory Therapy				
5 Speech				
6 Other				
7 Drugs				
8 *Total*				

ANNUAL COST REPORT--SCHEDULE F--ALLOCATION STATISTICS

VENDOR NAME _____ FYE _____

VENDOR NUMBER _____

A. NURSING SALARIES

1. CERTIFIED NURSING FACILITY _____
2. OTHER _____
3. CERT. NURSING FAC. PERCENTAGE _____%

ALLOCATION METHOD:

PATIENT DAYS ____ VALID TIME STUDY ____

DIRECT COST ____ DIRECT HOURS ____

OTHER APPROVED METHOD ____

B. SQUARE FOOTAGE

	(1) SQ. FT.	(2) PERCENT	(3) HOSPITAL-BASED SQ. FT.	(4) HOSPITAL-BASED PERCENT
1. CERT. NURSING FACILITY				
2. OTHER				
3. PHYSICAL THERAPY •				
4. X-RAY •				
5. LABORATORY •				
6. OXYGEN/RESP. THERAPY •				
7. SPEECH •				
8. OTHER •				
9. DRUGS •				
10. TOTAL				

• For Hospital-Based Certified Nursing Facility Only

C. DIETARY

	(1) MEALS	(2) PERCENT
1. CERT. NURSING FACILITY		
2. ALL OTHER		
3. TOTAL		

ALLOCATION METHOD:

MEAL COUNT ____ 3 x INPATIENT DAYS ____

D. ANCILLARY CHARGES

	(1) TOTAL	(2) CNF	(3) CNF %	(4) MEDICAID	(5) MEDICAID %
1. PHYSICAL THERAPY					
2. X-RAY					
3. LABORATORY					
4. OXYGEN/RESP. THERAPY					
5. SPEECH					
6. OTHER					
7. DRUGS					
8. TOTAL					

E. OCCUPANCY STATISTICS

	(1) CERTIFIED NURSING FACILITY	(2) OTHER LONG-TERM CARE	(3) ACUTE CARE
1. LICENSED BEDS AT BEGINNING OF PERIOD			
2. LICENSED BEDS AT END OF PERIOD			
3. BED DAYS AVAILABLE			
4. TOTAL PATIENT DAYS			
5. % OCCUPANCY			
6. KMAP PATIENT DAYS			
7. % KMAP OCCUPANCY			

F. ADDITIONAL STATISTICS

1. DIRECT ROUTINE NURSING HOURS - CERTIFIED NURSING FACILITY ONLY	
2. TOTAL DIRECT DIETARY HOURS	
3. TOTAL DIRECT HOUSEKEEPING HOURS	